

Understanding health care seeking behavior in a tribal setting in West Bengal

Pranita Taraphdar¹, Abhimanyu Vasudeva², Nishat Ahmed Sheikh³,
Ajay Bharti⁴, Asem Rangita Chanu⁵, S.L. Yadav⁵, Samantak Sahu⁶

¹Department of Community Medicine, DHGMCH (Diamond Harbour Government Medical College and Hospital), West Bengal, Departments of ²Physical Medicine and Rehabilitation, ³Forensic Medicine and Toxicology, ⁴Orthopedics, All India Institute of Medical Sciences, Gorakhpur, Uttar Pradesh, ⁵Department of Physical Medicine and Rehabilitation, All India Institute of Medical Sciences, New Delhi, ⁶Department of Physical Medicine and Rehabilitation, All India Institute of Medical Sciences, Jodhpur, Rajasthan, India

ABSTRACT

Background: The health-related problems of the tribal population depend on their ecology and culture. Often the tribal people do not utilize the medical and preventive health services available to them. Health problems in tribal groups need special attention because many tribal communities are backward. The current study was planned to determine the healthcare-seeking behavior of the tribal population in India. **Method:** A descriptive, cross-sectional study, conducted by interviewing key respondents of each participating family. **Result:** Two-thirds of the key respondents were literate and half (53.8%) of the total households in the three villages had a per capita monthly income between Rupees 500-1499. More than half (57%) of all respondents preferred government institutions for moderate illness, and the rest equally opted for private practitioners and quacks. However, for emergencies, dog bites, and snake bites, all key respondents in the three study villages unanimously preferred government institutions. A significant population (38.5%) got their children delivered at home. The majority of illiterate respondents (86.1%) preferred government institutions for health care of under-five children, while 60% of literates expressed a similar view. The choice of government institutions as a source of health care was increasingly favored with decreasing per capita monthly household income. **Conclusion:** Traditional healers are no longer preferred among the tribal population but they are reluctant to avail them because of the loss of valuable time. Home delivery is still prevalent. With improving socioeconomic status, people are going further away from government services as private practitioners, and quacks take less time.

Keywords: Health care systems, health care-seeking behavior, socio-economic status, tribal

Introduction

Tribals account for a sizable proportion of the Indian population (8.6 percent).^[1] Tribal population's health-related issues

Address for correspondence: Dr. Samantak Sahu,
Department of Physical Medicine and Rehabilitation, AIIMS,
Jodhpur, Rajasthan, India.
E-mail: samantaksahu00@gmail.com

Received: 10-07-2021

Revised: 08-12-2021

Accepted: 11-12-2021

Published: 18-03-2022

are determined by their ecology and culture.^[2] Traditional healing methods are used in primitive societies and are generally not recognized by state-supported, predominantly Western medical systems. Tribal people frequently do not use the medical and preventive health services that are available to them. Consequently, health issues in tribal groups require special attention.^[3]

Attempts have been made to document the health-seeking behavior of the tribal populations of Madhya Pradesh, Odisha, and Rajasthan.^[4-7] In the case of West Bengal, adequate data is lacking.

This is an open access journal, and articles are distributed under the terms of the Creative Commons Attribution-NonCommercial-ShareAlike 4.0 License, which allows others to remix, tweak, and build upon the work non-commercially, as long as appropriate credit is given and the new creations are licensed under the identical terms.

For reprints contact: WKHLRPMedknow_reprints@wolterskluwer.com

How to cite this article: Taraphdar P, Vasudeva A, Sheikh NA, Bharti A, Chanu AR, Yadav SL, *et al.* Understanding health care seeking behavior in a tribal setting in West Bengal. *J Family Med Prim Care* 2022;11:1443-9.

Access this article online

Quick Response Code:



Website:
www.jfmpc.com

DOI:
10.4103/jfmpc.jfmpc_1363_21

The tribes present in the Jhargram block of the West Midnapore district in West Bengal are mostly Santhal,^[8] an upcoming tribe who are gradually leaving their traditional migratory and hunter-gatherer occupation to adopt agriculture and government jobs.^[9] Hence, we planned an interview-based cross-sectional study with an objective to determine the healthcare-seeking behavior of tribal people residing in Jhargram block, West Midnapore district, West Bengal, to identify the socio-economic, demographic, and cultural factors determining the acceptance of modern health care services and to assess the perception of the study subjects regarding the health care services available. Knowledge of health-care seeking behavior is vital for primary care physicians.

Methodology

A descriptive, cross-sectional study, approved by the Institutional Ethics Committee R.G. Kar Medical College was conducted among the tribal population residing in Jhargram block, District West Midnapore in West Bengal, India. A multistage sampling technique was followed. A Detailed census report (2011) was accessed from the Block Development office of Jhargram. From the census report, a list of villages in the Jhargram block having a tribal population greater than 80% was prepared. From this list, villages were classified on the basis of distance from Jhargram town into 3 zones as follows:

- I. Less than 10 km from Jhargram
- II. 10 km–20 km from Jhargram
- III. More than 20 km from Jhargram

The villages were selected by simple random sampling from each of the three above mentioned zones. Fifty percent (50%) of the tribal households in the villages were selected by choosing every alternate house in the village. From each of the selected households, the head of the family was identified as the key respondent, and was interviewed regarding the health care seeking behavior of his family, after taking informed consent. The selected villages were:

1. Kumarduba (V1)- 22 km from Jhargram (32 households)
2. Kashia (V2)- 11 km from Jhargram (30 households)
3. Kannyaduba (V3)- 4 km from Jhargram (29 households)

A total of 91 households were selected for the study.

Independent variables were, distance from block headquarter, level of education and per capita income. Dependent variable

included choice of health care provider in case of moderate illness (no withdrawal from work), severe illness (withdrawal from work), emergency care, including animal bite (dog or snake bite), antenatal care, intra-natal care, post-natal care, care of the under-5 children, and immunization. Before data collection, community leaders and elected political leaders were approached for seeking cooperation.

Data processing and analysis

All data were collected by in-depth interviews of the key respondent of each household with the help of a pre-designed, pre-tested, semi-structured schedule after prior informed consent. Data were analyzed by appropriate statistical methods such as percentages, tests of significance such as Chi-square test, fisher's exact test with SPSS 16.0 (SPSS Inc. Released 2007. SPSS for Windows, Version 16.0. Chicago, SPSS Inc.). *P* value <0.05 was taken as significant.

Results

[Table 1] It was observed that overall almost two-thirds of the key respondents were literate. The proportion of key respondents who were literate in the village 1 and 2 were similar, (around 70%) but was much less in village 3 (41%). This difference was statistically significant ($p = 0.04$). Half (53.8%) of the total households in the three villages had per capita monthly income between Rupees 500-1499. However, the proportion varied in individual villages ranging from one-third in village 1, to two-third in village 2, to three-fourth in village 3. Households in village 1 were economically the weakest, with almost three-fourth having a per capita monthly income less than Rupees 500, whereas in villages 2 and 3 the proportion was approximately 7%. One-fourth of the households in village 2 had a per capita monthly income higher than Rupees 1500, which was proportionately the highest, compared to the other two villages ($p = <0.001$). In case of moderate illness, more than half (57%) of all respondents preferred government institutions, and the rest equally opted for private practitioners and quacks. In village 1, the most distant village from the block headquarter, the preference for government institutions was proportionately much higher (71.9%) than village 2 (46.7%), and village 3 (51.7%), but this difference was not statistically significant ($p = 0.84$). Preference for private practitioners was highest in village 2, (33.3%).

Table 1: Distribution of key respondents by Socio economic variables (Chi square test)

Socio economic variables	V1 >20 km (n1=32)	V2 10-20 km (n2=30)	V3 <10 km (n3=29)	Total (n=91)	<i>P</i>
Literacy					
Illiterate	10 (31%)	9 (30%)	17 (59%)	36 (40%)	<i>P</i> =0.039
Literate	22 (69%)	21 (70%)	12 (41%)	55 (60%)	
Per capita income (Rs)					
>= 1500	2 (6.2%)	8 (26.7%)	5 (17.3%)	15 (16.5%)	<i>P</i> <0.001
500-1499	7 (21.9%)	20 (66.7%)	22 (75.8%)	49 (53.8%)	
<500	23 (71.9%)	2 (6.6%)	2 (6.9%)	27 (29.7%)	
Total	32 (100)	30 (100)	29 (100)	91 (100)	

In case of severe illness, more than half (57.1%) of all respondents preferred private practitioners and the rest government institutions. In village 1 equal proportion of respondents opted for both sources and in village 2 two-thirds of respondents preferred private practitioners ($p = 0.4$). However, for emergency situations, dog bites, and snake bites, all key respondents in the three study villages unanimously preferred government institutions (Not in table). For antenatal care, the majority of the respondents (90% and above) in all three villages preferred government institutions. Only a small proportion went to private practitioners. Only in one household, no antenatal care was taken ($p = 0.99$).

Overall, 56% of all respondents preferred government institutions as a place of delivery, and more than one-third (38.5%) delivered at home. A small proportion (5.5%) went to private institutions. Though the majority of the respondents in villages 2 and 3 preferred government institutions, in village 1 which was most distant from the block headquarters, three-fourths of the respondents (75%) preferred home delivery. This difference was significant ($p < 0.001$). Regarding postnatal care majority of respondents (>90%) in all three villages preferred government institutions ($p = 0.98$). Regarding care of under-five children in illness, government institutions were the source of choice (70.3%) followed by private practitioners (27.5%). However, preference for private practitioners was highest in the village nearest to the town (37.9%) and lowest in the most distant village (18.8%) ($p = 0.63$).

For immunization all key respondents in the three study villages unanimously preferred government institutions. [Table 2] Among the key respondents who were illiterate, government institutions (75%) were the chosen health care provider in case of moderate illness, compared to 45.4% literates, who also gave considerable importance to private practitioners (29.1%). Preference for both private practitioners and quacks was two times more among literates (54.6%) than illiterates (25%). This difference was statistically significant ($p = 0.005$). In case of severe illness almost one third (61.1%) of key respondents preferred government institutions while a similar proportion (69.1%) among literates opted for private practitioners, the difference being statistically significant ($p = 0.004$).

Regarding antenatal care, most of the respondents (89% or more) preferred government institutions irrespective of literacy status. However, a slightly higher proportion of literate respondents opted for private practitioners, but this difference was not significant ($p = 0.23$). Just more than half of the key respondents (56%) preferred government institutions for intra natal care irrespective of literacy status ($p = 0.99$).

Most of the participants preferred government services in case of postnatal complications $P = 0.44$. Majority of illiterate respondents (86.1%) preferred government institutions for health care of under-five children, while 60% of literates expressed a similar view. Rather, a higher proportion of literates gave importance to private practitioners and quacks (30%), compared to the illiterate respondents (13.9%). This difference was statistically significant ($p = 0.007$) [Table 3].

Table 2: Distribution of preferred healthcare provider in moderate illness and distance from block headquarters (n=91) (Chi square test)

Sources of health care	V1 >20 km N1=32	V2 10-20 km N2=30	V3 <10 km N3=29	Total n=91	P
Moderate illness					
Govt institution	23 (71.9%)	14 (46.7%)	15 (51.7%)	52 (57%)	$P=0.84$
Private practitioner	3 (9.4%)	10 (33.3%)	6 (20.7%)	19 (21%)	
Quack	6 (18.7%)	6 (20%)	8 (27.6%)	20 (22%)	
Severe illness					
Govt institution	16 (50%)	10 (33.3%)	13 (44.8%)	39 (42.9%)	$P=0.40$
Private practitioner	16 (50%)	20 (66.7%)	16 (55.2%)	52 (57.1%)	
Ante natal care					
Govt institution	30 (93.8%)	27 (90%)	27 (93.1%)	84 (92.3%)	$P=0.99$
Private practitioner	2 (6.2%)	2 (6.7%)	2 (6.9%)	6 (6.6%)	
Home care	0	1 (3.3%)	–	1 (1.1%)	
Place of delivery					
Government Institution	6 (18.8%)	21 (70%)	24 (82.8%)	51 (56%)	$P<0.001$
Private Institution	2 (6.2%)	2 (6.7%)	1 (3.4%)	5 (5.5%)	
Home	24 (75)	7 (23.3)	4 (13.8)	35 (38.5)	
Sources of postnatal care					
Government institution	29 (90.6%)	28 (93.3%)	28 (96.6%)	85 (93.4%)	$P=0.98$
Private Practitioner	2 (6.3%)	2 (6.7%)	1 (3.4%)	5 (5.5%)	
Home care	1 (3.1%)	0	0	1 (1.1%)	
Under five children					
Government institution	25 (78.1%)	21 (70%)	18 (62.1%)	64 (70.3%)	$P=0.63$
Private Practitioner	6 (18.8%)	8 (26.7%)	11 (37.9%)	25 (27.5%)	
Quack	1 (3.1%)	1 (3.3%)	–	2 (2.2%)	
Total	32 (100%)	30 (100%)	29 (100%)	91 (100%)	

[Table 4] There was a considerable variation in preference of care provider in case of moderate illness among different groups of per capita income. With the increase in income, there was a shift in preference towards non-government health care providers. In the highest income group, private practitioners and quacks were preferred by almost three-fourths (73.3%), whereas it was the source of choice for only one-fourth of the respondents of the lowest income group, where government institution (77.8%) was preferred. These differences were statistically significant ($p = 0.005$). Even in case of severe illness, a shift in favor of private practitioners was observed with an increase in income, from one third (33.3%) in the lowest income group to almost two thirds (63.2%) in middle-income groups to four-fifths (80%) in the highest income group. These differences were statistically significant ($p = 0.006$). It was observed that though government institution was the choice regarding antenatal care (92.3%), one-fifth of the respondents from the highest income group opted for private practitioners ($p = 0.22$). Overall, government institutions were the most preferred place of delivery (56%). However, the majority (70.4%) of the respondents belonging to the lowest income group preferred home delivery, compared to almost one-fourth in the middle-income group. These differences were statistically significant ($p = 0.002$). Though government institutions were the choice of care provider regarding postnatal care, one-fourth of the highest income group opted for private practitioners ($p = 0.015$).

In case of the last episode of illness, government institutions were the most important source of health care sought in all the three study villages, the highest proportion (71%) being observed in

the village located farthest from the block. The next important source of health care were the private practitioners (ranging from 17%-27.8%), followed by quacks (ranging from 1.7% to 8.4%), and traditional healers (ranging from 1.7% to 4.4%). Home remedies were sought in overall 7.2% episodes of illness ($p = 0.31$).

Government institutions were the most preferred health facility irrespective of the literacy status of the key respondents. However, a higher proportion of households with literate key respondents preferred private providers (25%), compared to 18.6% of households where the key respondents were illiterate. Identical proportions of literate and illiterate key respondent households (5%) preferred treatment by quacks ($p = 0.19$).

The choice of government institutions as a source of health care was increasingly favored with decreasing per capita monthly household income. The proportion increased from 28.6% in households with per capita monthly income of more than Rupees 1500, to 77.7% in households with per capita monthly income less than Rupees 500. Again, the preference for private providers increased with an increase in income, from 9.3% in households with per capita monthly income less than Rupees 500, to 35.7% in households with per capita monthly income more than Rupees 1500. These differences were statistically significant ($p = 0.0017$). [Table 5]

Important problems faced by the respondents were loss of daily wages (100%), long waiting time (91%), unsuitable timing (89%), and unavailability of medicines (80%), inadequate bed strength (76%), and expensive treatments (75%). [Table 6]

Table 3: Distribution of preferred healthcare provider by medical condition and literacy (n=91) Chi square test, 2-Fisher Exact test-2 tailed)

Medical condition	Sources of health care	Illiterate N 1=36	Literate N 2=55	Total n=91	P
Moderate illness	Govt institution	27 (75%)	25 (45.4%)	52 (57%)	$P=0.005$
	Private Practitioner	3 (8.3%)	16 (29.1%)	19 (21%)	
	Quack	6 (16.7%)	14 (25.5%)	20 (22%)	
Severe illness	Government institution	22 (61.1%)	17 (30.9%)	39 (42.9%)	$P=0.004$
	Private Practitioner	14 (38.9%)	38 (69.1%)	52 (57.1%)	
Ante natal care	Government Institution	35 (97.2%)	49 (89.1%)	84 (92.3%)	$P=0.23$
	Private Practitioner	1 (2.8%)	5 (9.1%)	6 (6.6%)	
	Home care	–	1 (1.8%)	1 (1.1%)	
Intra- natal Care	Government institution	20	31	51 (56%)	$P=0.99$
		55.6%	56.4%		
	Private institution	2	3	5 (5.5%)	
	Home	5.5%	5.4%		
Post natal care		14	21	35 (38.5%)	$P=0.44$
		38.9%	38.2%		
	Government institution	36 (100%)	49 (89.1%)	85 (93.4%)	
	Private practitioner	–	5 (9.1%)	5 (5.5%)	
	Home care	–	1 (1.8%)	1 (1.1%)	
	Source of care	Illiterate N 1=36	Literate N 2=55	Total n=91	
Care of Under five children	Govt institution	31 (86.1%)	33 (60%)	64 (70.3%)	$P=0.007$
	Private Practitioner	4 (11.1%)	21 (28.2%)	25 (27.5%)	
	Quack	1 (2.8%)	1 (1.8%)	2 (2.2%)	
	Total	36 (100%)	55 (100%)	91 (100%)	

Table 4: Distribution of preferred healthcare provider by medical condition and per capita monthly household income (n=91) (Chi Square Test)

Medical Condition	Source of care	>Rs 1500 N 1=15	Rs 500-Rs 1499 N 2=49	<Rs 500 N 3=27	Total n=91	P
Moderate illness	Government Institution	4 (26.7%)	27 (55%)	21 (77.8%)	52 (57%)	P=0.005
	Private practitioner	5 (33.3%)	9 (18.4%)	5 (18.5%)	19 (21%)	
	Quack	6 (40%)	13 (26.6%)	1 (3.7%)	20 (22%)	
Severe illness	Government Institution	3 (20%)	18 (36.7%)	18 (66.7%)	39 (42.9%)	P=0.006
	Private practitioner	12 (80%)	31 (63.3%)	9 (33.3%)	52 (57.1%)	
	Quack	-	-	-	-	
Antenatal care	Govt institution	12	46	26	84	P=0.22
		80%	93.88%	96.30%	92.3%	
	Private practitioner	3	2	1	6	
		20%	4.08%	3.70%	6.6%	
Place of delivery	Home care	-	1	0	1	P=0.002
		-	2.04%	-	1.1%	
	Government institution	8 (53.4%)	35 (71.4%)	8 (29.6%)	51 (56%)	
Post natal care	Private institution	2 (13.3%)	3 (6.1%)	0	5 (5.5%)	P=0.015
	Home	5 (33.3%)	11 (22.5%)	19 (70.4%)	35 (38.5%)	
	Government institution	11 (73.3%)	49 (100%)	25 (92.6%)	85 (93.4%)	
Under five children	Private practitioner	4 (26.7%)	-	1 (3.7%)	5 (5.5%)	P=0.47
	Home care	-	-	1 (3.7%)	1 (1.1%)	
	Government institution	9	34	21	64	
		60%	69.39%	77.78%	70.3%	
	Private practitioner	6	15	4	25	
Total	Quack	0	-	2	2	P=0.001
				7.41%	2.2%	
		15	49	27	91 (100%)	
		100%	100%	100%		

Table 5: Distribution of sources of health care sought in last episode of illness (n=139)

	Source of care	Government institution	Private practitioner	Quack	Traditional healer	Home remedy	Total	P
Distance	V1	41 (71%)	10 (17%)	1 (1.7%)	1 (1.7%)	5139 (8.6%)	58 (100%)	P=0.31
	>20 km							
	N1=58							
Literacy status	V2	21 (58.3%)	10 (27.8%)	3 (8.4%)	0	2 (5.5%)	36 (100%)	P=0.19
	10-20 km							
	N2=36							
Per capita income	V3	26 (57.8%)	11 (24.4%)	3 (6.7%)	2 (4.4%)	3 (6.7%)	45 (100%)	P=0.001
	<10 km							
	N3=45							
Total	Literate	47 (58.8%)	20 (25%)	4 (5%)	3 (3.7%)	6 (7.5%)	80 (100%)	P=0.001
	Illiterate	41 (69.5%)	11 (18.6%)	3 (5.1%)	0	4 (5.1%)	59 (100%)	
	>=1500	4 (28.6%)	5 (35.7%)	3 (21.4%)	0	2 (14.3)	14 (100%)	
	N 1=14							
Total	500-1499	42 (59.2%)	21 (29.5%)	4 (5.6%)	1 (1.5)	3 (4.2%)	71 (100%)	P=0.001
	N 2=71							
	<500	42 (77.7%)	5 (9.3%)	0	2 (3.7%)	5 (9.3%)	42 (100%)	
	n3=54							
	Total	88 (63.3%)	31 (22.3%)	7 (5.0%)	3 (2.2%)	10 (7.2%)	139 (100%)	

Discussion

Poverty and illiteracy, as well as ignorance and geographical isolation, are major impediments to improving tribal health. Tribal socio-cultural norms differ from those of the general

population, with distinct civilization, rituals, and reliance on forest and traditional agricultural technology.^[10]

In the study, the characteristics and determinants of healthcare-seeking behaviour of tribal people of the Jhargram block were observed.

Table 6: Distribution of key respondents by their perception about government health care services (n=91) multiple response

Problems faced	No of respondents	%
Loss of daily work	91	100
Long waiting time	83	91
Unsuitable timing	81	89
Unavailability of medicine	73	80
Inadequate bed	69	76
Expensive treatment	69	75
Inadequate privacy for female patients	64	70
Long distance	56	61
Inadequate emergency care	48	53
Unavailability of doctors	35	38
Bad quality of medicine	24	26
Unsatisfactory treatment	13	14
Indifferent behavior of health care provider	8	9

Overall, almost two-thirds of the key respondents were literate. The proportion of key respondents who were literate in villages 1 and 2 were similar, (around 70%) but was much less in village 3 (41%), which was also the village nearest to the block headquarters. Half (53.8%) of the total households in the three villages had a per capita monthly income between Rupees 500-1499. However, the proportion varied in individual villages ranging from one-third in village 1 to two-thirds in village 2, to three-fourths in village 3. Village 1, the most distant village was also economically the weakest, with almost three-fourths households having a per capita monthly income of less than Rupees 500, whereas in villages 2 and 3 the proportion was approximately 7%. One-fourth of the households in village 2 had a per capita monthly income higher than Rupees 1500, which was proportionately the highest, compared to the other two villages. In such a community, cost-effectiveness should be on highest priority while implementing any healthcare intervention.

In village 1 more respondents opted for government institutions probably due to their poor socioeconomic status. Among literates, more respondents preferred private practitioners and quacks. This may be due to the fact that as literates have better socioeconomic status, they are able to pay for private practitioners and quacks. Similarly, it was observed that with increasing per capita income, utilization of government services decreased and the reverse was true for private practitioners and quacks. In the highest income group, 40% of respondents preferred quacks. This is supported by a study on tribals of Rajasthan, where it was found that a considerable amount of money and time is spent by these people on health due to ignorance and bad experience about state health set up, and they visit ill-qualified medical practitioners.^[5] It was observed that the tribals changed their preferred sources of care according to the severity of illness. In case of moderate illness, where they were able to continue their daily work, a considerable proportion (22%) preferred quacks. The most important causes were the easy availability of the quacks, and also the medicines carried by them. In village 1, the most distant village from the block headquarter, the preference for government institutions was proportionately much higher (71.9%) than village 2 (46.7%), and village 3 (51.7%)

In case of severe illness which entailed withdrawal from work, none preferred quacks. Here, the preferred choice was private practitioners followed by government services. These findings are supported by a study on Santhals of Orissa where it was observed that people preferred going to modern health facilities in case of serious disease.^[6] In emergency situations, dog bites and snake bites, all key respondents in the three study villages unanimously preferred government institutions, because they were aware that facilities for treatment of serious conditions existed only in government institutions. However, when probed on their perception about government services, only 53% respondents opined that emergency services were adequate. Many believed that modern treatment is more effective in snake bites. Some respondents observed that good traditional healers were not available these days, so hospitals are preferred. This observation is different in another study among tribal of Rajasthan, where over 80% of snakebite, scorpion sting, and other poisoning cases were cared by faith healers.^[5]

Regarding antenatal care, all except one respondent stated that they would like to seek care preferably from a government institution. However, 20% of the highest income group opted for private practitioners. In this regard, a respondent remarked that these days Accredited Social Health Activists and Anganwadi workers try to convince people to seek antenatal care. However, most of the villagers still want home delivery, though they go to the government hospital in case of life-threatening postnatal complications. This observation was consistent with the study findings. More than one-third of all respondents preferred home delivery, and it was three-fourth in the case of village.^[1] However, most of the respondents opted for government institutions when they considered it as an emergency situation. These practices may lead to more incidences of poorly managed perinatal emergencies. It was also observed in a study on Santhals of Orissa that there was a general notion of tribal people that healthy women did not need to give birth outside the home. A healthy woman was one who could give birth to her babies without any complications, without the knowledge of outsiders, and without interference with day-to-day activities.^[3] Home delivery was preferred, as this was their custom.

In the case of seeking the care of under-five children government institutions were the source of choice followed by private practitioners. However, utilization of private care increased with an increase in per capita income. For immunization services, all key respondents in the three study villages unanimously preferred government institutions.

The choice of government institutions as a source of health care was increasingly favored with decreasing per capita monthly household income. The proportion increased from 28.6% in households with per capita monthly income of more than Rupees 1500, to 77.7% in households with per capita monthly income less than Rupees 500. Again, the preference for private providers increased with increase in income, from 9.3% in households with per capita monthly income less than Rupees 500, to 35.7% in households with per capita monthly income more than Rupees 1500. These differences were statistically significant.

Respondents were dissatisfied with government healthcare services; major problems being long waiting time, unavailability of medicines, and loss of daily work, unsuitable timing. This fact is also highlighted in a study among tribals of Rajasthan where the problems faced by people while utilizing government health services were inaccessibility due to lack of transportation, the unsympathetic attitude of the staff and non-availability of medicines.^[5] Similar findings were demonstrated in several recent studies.^[11-13] Delving into the determinants of health care seeking behavior will benefit all stakeholders, but especially those who are the first point of contact, i.e., primary care physicians.

Conclusion

Traditional healers are no longer preferred among the tribal population of Jhargram block, West Midnapore district, West Bengal. They know the superiority of modern health services but are reluctant to avail them because of loss of valuable time. With improvement in socioeconomic status, people are going further away from government services as services of private practitioners and quacks takes less time.

Limitations and recommendations

This research was carried out in Jhargram block, which is also the headquarters of the Jhargram sub-division. A larger study that includes the entire sub-division could shed more light on the factors that influence health-care utilisation.

Key points

1. Traditional healers are no longer popular among tribal people, but they are hesitant to avail their services them due of the time investment
2. People are moving away from government services in favour of private practitioners as their socioeconomic status improves.

Novelty

Tribals of Jhargram block, West Midnapore district, West Bengal, recognize the superiority of modern health services but are hesitant to use them due to time loss.

Acknowledgements

Professor Surekha Kishore, Executive Director AIIMS Gorakhpur for her emphasis on research and innovation.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

References

1. Census of India Website: Office of the Registrar General and Census Commissioner, India. Available from: <https://www.censusindia.gov.in/2011census/HLO/HH14.html>. [Last accessed on 2021 Jul 4].
2. Finn S, Herne M, Castille D. The value of traditional ecological knowledge for the environmental health sciences and biomedical research. *Environ Health Perspect* 2017;125:085006.
3. Basu S, Kapoor AK, Basu SK. Knowledge, attitude and practice of family planning among tribals. *J Fam Welf* 2004;50:7.
4. Palzor D. Health care beliefs and practices among Garasia Tribe in Udaipur district of Rajasthan. University. 2019. Available from: <http://shodhganga.inflibnet.ac.in:8080/jspui/handle/10603/274214>. [Last accessed on 2021 Jul 4].
5. Singh LP, Gupta SD. Health Seeking Behaviour and Healthcare Services in Rajasthan, India: A Tribal Community's Perspective. Available from: <https://www.popline.org/node/522198>. [Last accessed on 2021 Jun 30].
6. Pati S, Chauhan AS, Panda M, Swain S, Hussain MA. Neonatal care practices in a tribal community of Odisha, India: A cultural perspective. *J Trop Pediatr* 2014;60:238-44.
7. Pandey GD, Roy J, Tiwary RS. Socio-cultural aspects and health care in Pando tribe of Madhya Pradesh. *J Hum Ecol* 2001;12:391-4.
8. Bose K, Banerjee S, Bisai S, Mukhopadhyay A, Bhadra M. Anthropometric profile and chronic energy deficiency among adult santal tribals of Jhargram, West Medinipur District, West Bengal, India: Comparison with other tribal populations of Eastern India. *Ecol Food Nutr* 2006;45:159-69.
9. Sonowal CJ, Praharaj P. Tradition Vs transition: Acceptance of health care systems among the Santhals of Orissa. *Stud Ethno-Med* 2007;1:135-46.
10. Sachdev B. Perspectives on health, health needs and health care services among select nomad tribal populations of Rajasthan, India. *Antrocom Online J Anthro* 2012;8:9.
11. Kumar MM, Pathak VK, Ruikar M. Tribal population in India: A public health challenge and road to future. *J Family Med Prim Care* 2020;9:508-12.
12. Sengupta A, Sahoo M, Khan A, Shaikh R, Khan R. Maternal health status in tribal India: A 5-year intervention program and its outcome. *Indian J Community Med* 2020;45:189-93.
13. Hussain T, Tripathy SS, Das S, Satapathy P, Das D, Thomas B, *et al.* Prevalence, risk factors and health seeking behaviour of pulmonary tuberculosis in four tribal dominated districts of Odisha: Comparison with studies in other regions of India. *PLoS One* 2020;15:e0227083.